FOR OHF USE

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042192

Facility Name: Alden Orland Park Rehab & HCC

Address: 16450 South 97th Avenue (Number) Orland Park (City) 60462 (Zip Code)

County: Cook

Telephone Number: (708) 403-6500 **Fax #** (708) 873-9774

IDPA ID Number: 36-3901683

Date of Initial License for Current Owners: 01/08/98

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: **Telephone Number:** ( )

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)

(Type or Print Name) Joan Carl

(Title)

Paid Preparer

(Signed) (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Alden Orland Park Rehab & HCC # 0042192 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	200	Skilled (SNF)	200	73,000	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	200	TOTALS	200	73,000	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,565	14,973	21,893	49,431	8
9	SNF/PED					9
10	ICF	3,089	2,024	37	5,150	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,654	16,997	21,930	54,581	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.77%

D. How many bed-hold days during this year were paid by the Department?
none (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/19/98

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 200 and days of care provided 19,652

Medicare Intermediary ADMINASTAR FEDERAL, INC.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Alden Orland Park Rehab & HCC # 0042192 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	562,288	43,119	9,600	615,007	1,115	616,122	(5,126)	610,996			1
2	Food Purchase		385,109		385,109	(21,469)	363,640	6,091	369,731			2
3	Housekeeping	242,626	48,733		291,359	628	291,987		291,987			3
4	Laundry	84,320	18,954		103,274	450	103,724		103,724			4
5	Heat and Other Utilities			230,546	230,546		230,546	(8,580)	221,966			5
6	Maintenance	52,717		146,775	199,492	61	199,553	8,573	208,126			6
7	Other (specify):* **Related Party Salary**							47,230	47,230			7
8	**TOTAL General Services**	941,951	495,915	386,921	1,824,787	(19,215)	1,805,572	48,188	1,853,760			8
	B. Health Care and Programs											
9	Medical Director			30,500	30,500		30,500		30,500			9
10	Nursing and Medical Records	3,077,967	173,122	153,035	3,404,124	(70,715)	3,333,409	1,807	3,335,216			10
10a	Therapy	75,961			75,961		75,961		75,961			10a
11	Activities	109,833	5,277	5,006	120,116	68	120,184		120,184			11
12	Social Services	53,577			53,577		53,577		53,577			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* **Related Party Salary**							27,611	27,611			15
16	**TOTAL Health Care and Programs**	3,317,338	178,399	188,541	3,684,278	(70,647)	3,613,631	29,418	3,643,049			16
	C. General Administration											
17	Administrative	160,733			160,733		160,733		160,733			17
18	Directors Fees											18
19	Professional Services			1,042,564	1,042,564		1,042,564	(985,280)	57,284			19
20	Dues, Fees, Subscriptions & Promotions			72,867	72,867	(4,971)	67,896	(48,981)	18,915			20
21	Clerical & General Office Expenses	265,925	31,014	69,667	366,606	4,037	370,643	(41,442)	329,201			21
22	Employee Benefits & Payroll Taxes			759,545	759,545	11,161	770,706	(14,816)	755,890			22
23	Inservice Training & Education					72,653	72,653		72,653			23
24	Travel and Seminar			3,416	3,416	1,250	4,666	15,782	20,448			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			221,030	221,030		221,030	14,781	235,811			26
27	Other (specify):* **Related Party Salary**			(8,139)	(8,139)		(8,139)	430,705	422,566			27
28	**TOTAL General Administration**	426,658	31,014	2,160,950	2,618,622	84,130	2,702,752	(629,251)	2,073,501			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,685,947	705,328	2,736,412	8,127,687	(5,732)	8,121,955	(551,645)	7,570,310			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Alden Orland Park Rehab & HCC #0042192 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			49,469	49,469		49,469	399,611	449,080			30
31	Amortization of Pre-Op. & Org.			1,100	1,100		1,100	2,421	3,521			31
32	Interest			254,674	254,674		254,674	773,232	1,027,906			32
33	Real Estate Taxes							596,666	596,666			33
34	Rent-Facility & Grounds			1,614,034	1,614,034		1,614,034	(1,614,034)				34
35	Rent-Equipment & Vehicles			15,779	15,779		15,779	26,936	42,715			35
36	Other (specify):*							72,284	72,284			36
37	**TOTAL Ownership**			1,935,056	1,935,056		1,935,056	257,116	2,192,172			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		922,585	1,313,778	2,236,363	5,732	2,242,095	(325,847)	1,916,248			39
40	Barber and Beauty Shops	47,643			47,643		47,643		47,643			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			109,500	109,500		109,500		109,500			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	47,643	922,585	1,423,278	2,393,506	5,732	2,399,238	(325,847)	2,073,391			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,733,590	1,627,913	6,094,746	12,456,249		12,456,249	(620,376)	11,835,873			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Alden of Orland Park
Reporting Period Beginning 1/1/2005
Reporting Period Ending 12/31/2005

Reclassifications

From Line	To Line	Amount	Description
2		(21,469.00)	Employee Meals
	22	21,469.00	Employee Meals
22		(10,308.00)	Uniform
	1	1,115.00	Uniform
	3	628.00	Uniform
	4	450.00	Uniform
	6	61.00	Uniform
	10	7,670.00	Uniform
	11	68.00	Uniform
	21	316.00	Uniform
10		(72,653.00)	Dart Chart Fees
	23	72,653.00	Dart Chart Fees
10		(5,732.00)	Oxygen
	39	5,732.00	Oxygen
20		(1,321.00)	Resident Background Check
	21	1,321.00	Resident Background Check
20		(2,400.00)	eHealth Data Solutions
	21	2,400.00	eHealth Data Solutions
20		(1,250.00)	Deming Training
	24	1,250.00	Deming Training

0.00 Net

Facility Name & ID Number Alden Orland Park Rehab & HCC # 0042192 Report Period Beginning: 01/01/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2,145	30		9
10	Interest and Other Investment Income	(97)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,866)	2		13
14	Non-Care Related Interest	(7,420)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(6,135)	21		17
18	Fines and Penalties				18
19	Entertainment	(955)	20		19
20	Contributions	(1,288)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(22,170)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	8,139	27		24
25	Fund Raising, Advertising and Promotional	(40,768)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,899)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (74,314)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(423,052)	Various	34
35	Other- Attach Schedule	(123,010)	Pg 5A	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (546,062)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (620,376)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Alden Orland Park Rehab & HCC

ID# 0042192

Report Period Beginning: 01/01/05

Ending: 12/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Back out prior year accounting fees(7143) Blackman	$ 2,964	19	1
2	Simplex Grinnell(7143)	(300)	6	2
3	Late fees on utilities	(10,931)	5	3
4	Late fees on telephone (6843)	(176)	21	4
5	Utility refunds	(487)	5	5
6	Marketing Manager (6701-100-009)	(92,333)	21	6
7	Reclass prior year accounting fees(7143) Blackman	(2,964)	21	7
8	Back out pac of 32.97 of IHCA dues	(3,640)	20	8
9	Collections Back Out	(2,220)	19	9
10	Adj Depreciation for correct amount	1,593	30	10
11	Reclass Vendor settlement Simplex Grinnell	300	21	11
12	Deduct Mkts Manager Employee Benefits	(14,816)	22	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(123,010)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Alden Orland Park Rehab & HCC # 0042192 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	(5,126)	0	0	0	0	0	0	0	(5,126)	1
2	Food Purchase	(2,866)	0	0	8,957	0	0	0	0	0	0	0	6,091	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(11,418)	0	2,838	0	0	0	0	0	0	0	0	(8,580)	5
6	Maintenance	(300)	0	8,449	0	0	0	424	0	0	0	0	8,573	6
7	Other (specify):*	0	0	42,536	4,694	0	0	0	0	0	0	0	47,230	7
8	**TOTAL General Services**	(14,584)	0	53,823	8,525	0	0	424	0	0	0	0	48,188	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	3,834	(2,027)	0	0	0	0	0	0	1,807	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	27,611	0	0	0	0	0	0	0	0	27,611	15
16	**TOTAL Health Care and Programs**	0	0	27,611	3,834	(2,027)	0	0	0	0	0	0	29,418	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(21,426)	4,200	(968,054)	0	0	0	0	0	0	0	0	(985,280)	19
20	Fees, Subscriptions & Promotions	(49,550)	0	569	0	0	0	0	0	0	0	0	(48,981)	20
21	Clerical & General Office Expenses	(101,308)	693	29,809	9,983	19,381	0	0	0	0	0	0	(41,442)	21
22	Employee Benefits & Payroll Taxes	(14,816)	0	0	0	0	0	0	0	0	0	0	(14,816)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	15,782	0	0	0	0	0	0	0	0	15,782	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	14,544	237	0	0	0	0	0	0	0	0	14,781	26
27	Other (specify):*	8,139	0	386,123	14,774	21,669	0	0	0	0	0	0	430,705	27
28	**TOTAL General Administration**	(178,961)	19,437	(535,534)	24,757	41,050	0	0	0	0	0	0	(629,251)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(193,545)	19,437	(454,100)	37,116	39,023	0	424	0	0	0	0	(551,645)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Alden Orland Park Rehab & HCC **#** 0042192 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	3,738	385,977	8,035	0	1,861	0	0	0	0	0	0	399,611	30
31	Amortization of Pre-Op. & Org.	0	896	1,525	0	0	0	0	0	0	0	0	2,421	31
32	Interest	(7,517)	705,994	66,572	0	3,642	4,541	0	0	0	0	0	773,232	32
33	Real Estate Taxes	0	589,036	6,206	0	1,424	0	0	0	0	0	0	596,666	33
34	Rent-Facility & Grounds	0	(1,614,034)	0	0	0	0	0	0	0	0	0	(1,614,034)	34
35	Rent-Equipment & Vehicles	0	0	26,936	0	0	0	0	0	0	0	0	26,936	35
36	Other (specify):*	0	72,284	0	0	0	0	0	0	0	0	0	72,284	36
37	**TOTAL Ownership**	(3,779)	140,153	109,274	0	6,927	4,541	0	0	0	0	0	257,116	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	(170,766)	(124,056)	(31,025)	0	0	0	0	0	(325,847)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	(170,766)	(124,056)	(31,025)	0	0	0	0	0	(325,847)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(197,324)	159,590	(344,826)	(133,650)	(78,106)	(26,484)	424	0	0	0	0	(620,376)	45

Facility Name & ID Number Alden Orland Park Rehab & HCC # 0042192 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6L		See Page 6K	See Page 6K		See Page 6K	

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Lease revenue	$ 1,614,034	Orland Associates Limited Partnership		$	$ (1,614,034)	1
2	V	32	Interest-Income-Tenant	149,892	Orland Associates Limited Partnership			(149,892)	2
3	V	19	Accounting Fees		Orland Associates Limited Partnership		4,200	4,200	3
4	V	21	Misc Admin Fees		Orland Associates Limited Partnership		693	693	4
5	V				Orland Associates Limited Partnership				5
6	V	33	Real Estate Tax Expense		Orland Associates Limited Partnership		589,036	589,036	6
7	V	26	Insurance Expense		Orland Associates Limited Partnership		14,544	14,544	7
8	V	32	Interest Expense		Orland Associates Limited Partnership		857,245	857,245	8
9	V	36	Mortgage Insurance Expense		Orland Associates Limited Partnership		72,284	72,284	9
10	V	30	Depreciation		Orland Associates Limited Partnership		385,977	385,977	10
11	V	31	Amortization		Orland Associates Limited Partnership		896	896	11
12	V	32	Interest-Income-non-related party	1,359	Orland Associates Limited Partnership			(1,359)	12
13	V								13
14	Total			$ 1,765,285			$ 1,924,875	$ * 159,590	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Alden Orland Park Rehab & HCC # 0042192 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Fees	$ 983,769	Alden Management Services		$ 15,715	$ (968,054)	15
16	V	21	Gen'l & Admin		Alden Management Services		29,809	29,809	16
17	V	5	Utilities		Alden Management Services		2,838	2,838	17
18	V	6	Repair/Mainten.		Alden Management Services		8,449	8,449	18
19	V	24	Travel/Seminar		Alden Management Services		15,782	15,782	19
20	V	26	Insurance		Alden Management Services		237	237	20
21	V	20	Dues/Subscriptions		Alden Management Services		569	569	21
22	V	30	Depreciation		Alden Management Services		8,035	8,035	22
23	V	31	Amortization		Alden Management Services		1,525	1,525	23
24	V	33	Real Estate Taxes		Alden Management Services		6,206	6,206	24
25	V	35	Rent-Equip & Vehic		Alden Management Services		26,936	26,936	25
26	V	32	Interest		Alden Management Services		66,572	66,572	26
27	V	7	Gen'l Service Salary		Alden Management Services		42,536	42,536	27
28	V	15	Health Care Salary		Alden Management Services		27,611	27,611	28
29	V	27	Gen'l & Admin Salary		Alden Management Services		386,123	386,123	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 983,769			$ 638,943	$ * (344,826)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Orland Park Rehab & HCC # 0042192 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		1	Dietary Consultant	$ 9,600	Prism Health Care		$ 4,474	$ (5,126)	15
16	V		7	Dietary Sal & Wages		Prism Health Care		4,694	4,694	16
17	V		2	Tude Feeding	1,792	Prism Health Care		10,749	8,957	17
18	V		10	Equipment Rental-patient care	3,060	Prism Health Care		6,894	3,834	18
19	V		39	Ancillary supplies	224,821	Prism Health Care		54,055	(170,766)	19
20	V		39	Ancillary Vent Rentals		Prism Health Care				20
21	V		27	Gen'l & Admin Salaries		Prism Health Care		14,774	14,774	21
22	V		21	Gen'l & Admin Expense		Prism Health Care		9,983	9,983	22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 239,273			$ 105,623	$ * (133,650)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Orland Park Rehab & HCC # 0042192 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Drugs	$ 368,860	Forum Extended Care II		$ 524,973	$ 156,113	15
16	V	10	House Stock	9,238	Forum Extended Care II		8,193	(1,045)	16
17	V	39	IV	327,822	Forum Extended Care II		47,887	(279,935)	17
18	V	39	Wound Vac	1,081	Forum Extended Care II		847	(234)	18
19	V	10	Pharmacy Consulting	7,650	Forum Extended Care II		6,668	(982)	19
20	V	27	Employee Vaccin	2,117	Forum Extended Care II		1,657	(460)	20
21	V	27	G & A Salary		Forum Extended Care II		22,129	22,129	21
22	V	21	Gen'l Admin		Forum Extended Care II		19,381	19,381	22
23	V	32	Interest		Forum Extended Care II		3,642	3,642	23
24	V	33	Real Estate Tax		Forum Extended Care II		1,424	1,424	24
25	V	30	Depreciation				1,861	1,861	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 716,768			$ 638,662	$ * (78,106)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Orland Park Rehab & HCC # 0042192 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Therapy	$ 1,266,210	Community Physical Therapy		$ 1,235,185	$ (31,025)	15
16	V	32	Interest Expense		Community Physical Therapy		4,541	4,541	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,266,210			$ 1,239,726	$ * (26,484)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Orland Park Rehab & HCC # 0042192 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Repairs & Maintenance	$ 18,041	Alden Bennett Construction		$ 18,465	$ 424	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 18,041			$ 18,465	$ * 424	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDEN NURSING CENTER - ORLAND PARK # 004-2192 **Report Period Beginning** 01/01/05 **Ending:** 12/31/05

RELATED NURSING HOMES	
Name	City
Note: ANC = Alden Nursing Center	
ANC Lakeland	Chicago
ANC Long Grove	Long Grove
ANC Heather	Harvey
ANC Lincoln Park	Chicago
ANC Waterford	Aurora
ANC Town Manor	Chicago
ANC Terrace of McHenry	McHenry
ANC Morrow	Chicago
ANC Wentworth	Chicago
ANC Naperville	Naperville
ANC Valley Ridge	Bloomingdale
ANC Village for Children & Young Adults	Bloomingdale
ANC Northmoor	Chicago
ANC Princeton	Chicago
Alden of Old Town East	Bloomingdale
Alden of Old Town West	Bloomingdale
Alden Trails	Bloomingdale
Alden Northshore	Skokie
ANC Des Plaines	Des Plaines
ANC Des Plaines II	Des Plaines
ANC Alma Nelson	Rockford
ANC Park Stratmoor	Rockford
ANC Meadow Park	Clinton, WI
ANC Poplar Creek	Hoffman Estates
ANC Governor's Park	Barrington
ANC Gardens of Rockford	Rockford

OTHER RELATED BUSINESS ENTITIES		
Name	City	Type of Business
The Forum Prof. Center	Chicago	Office rental
Prism Health Care	Chicago	Nursing supplies
Forum Extended Care II	Chicago	Pharmacy
Alden Management	Chicago	Management
Alden Estates of Evanston	Evanston	Assisted living
Community Physical Thereapy	Wood Dale	Therapy provider
Courts of Waterford	Aurora	Alzheimers unit
Gardens of Waterford	Aurora	Assisted living

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NAME	OP
LU SEZENOV	4
MILDRED SCHLOSSBERG	5
RONALD EATON	7
JOHN VERCILLO	1
LARRY SAUNDERS	1
FAS OF PTN	(26)
FAS OF CORP	37
AMS OF PTN (FAS OWNS 'S" CORP	(11)
JOAN/SAM CARL (*5.5% Split - 1 each- Hannah, Harry, Chloe, Alex; 3/4% each Pam and Rob)	8
RITCHIE SCHULLO	3
RANDI SCHULLO	2
JACK & MARILYN FRYMIRE	1/2
BRUCE JOHNSON	2
AUDRA ELISCO	1/4
BRIAN KRAMER	LOAN 1/4
AMI PISSETZKY	LOAN 1
JOSEPH AMENT	1/2
GLORIA FISCH	1
ROBERT MOLITOR	1/2
DAVID MENN	1
STEVEN KRAMER	1/2
RAYMOND & DARLENE SCHULTZ	1/2
MARY CHELOTTI-SMITH	1/2
HERSHEL HERRENDORF	2
M. HEATHER BUSHONG	1
RICHARD DONCHIN	1/2
JOSHUA HERRENDORF	1/2
DON NADICK	1/2
HARVEY & MARCIA BRIN	1
LAUREN & TERRY MAGNUSSION	1/4
CHARLES GIGER	10
JAMES GIGER	7 3/4
TOTALS	**100**

Facility Name & ID Number Alden Orland Park Rehab & HCC # 0042192 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd Schlossberg a.	President	Chief Executive	100.00	132,841	1.908	4.77	Salary	$ 6,659	27-7	1
2	Lauren Magnusson b.	Nurse Coordinator	Nursing Admin.		72,138	1.908	4.77	Salary	3,616	15-7	2
3	Terry Magnusson c.	Maint. Supervisor	Construct/Maint.		49,042	1.908	4.77	Salary	2,458	7-7	3
4	Joan Carl d.	Secretary	Vice-President		132,841	1.908	4.77	Salary	6,659	27-7	4
5											5
6											6
7	a. Floyd Schlossberg is the President and sole stockholder of Alden Management sevices, Inc.										7
8	b.Lauren Magnusson is the daughter of Floyd Schlossberg. Lauren is a nurse coordinator										8
9	c. Terry Magnusson is the son-in-law of Floyd Schlossberg. Terry is in maintenance and construction.										9
10	d. Joan Carl is the Secretary of Alden Management Services and all mursing facilities. Shehas an equity interest in Town Manor, Princeton, Valley Ridge,										10
11	North Shore, Orland Park, and Waterford. She has an equity interest in the real estate of Alma Nelson, Park Strathmoor, and Meadow Park.										11
12											12
13								TOTAL	$ 19,392		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Alden Orland Park Rehab & HCC # 0042192 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Ami Pissetzki	Investor Relations	Invest/bank	1.00	132,841	1.908	4.77	Salary	$ 6,659	27-7	1
2	Bob Molitor	VP of Operations	Operations	0.50	147,601	1.908	4.77	Salary	7,399	27-7	2
3	Mary Chelotti Smith	In-house Counsel	Legal Advis.	0.50	288,032	1.908	4.77	Salary	14,439	27-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 28,497		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number Alden Orland Park Rehab & HCC # 0042192 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Alden Management Services, Inc
Street Address: 4200 W. Peterson Ave.
City / State / Zip Code: Chicago, IL 60646
Phone Number: (773) 286-3883
Fax Number: (773) 286-3743

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		see page 8A(same as page 6A)				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Alden Orland Park Rehab & HCC # 0042192 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Cambridge		X	Mortgage	$84,306.29	4/2003	$ 12,105,000	$ 11,890,806	4/2043	5.9300	$ 857,245	1
2	Cambridge		X	Operations	$17,852.36	4/2003	2,563,300	2,517,943	4/2043	5.9300	97,361	2
3												3
4												4
5												5
	Working Capital											
6	Related Party-AMS	X		Working Capital							66,572	6
7	Related Party-FECII	X		Working Capital							3,642	7
8	Related Pary-CPT	X		Working Capital							4,541	8
9	TOTAL Facility Related				$102,158.65		$ 14,668,300	$ 14,408,749			$ 1,029,361	9
	B. Non-Facility Related*											
10	Interest Income on RR										(1,359)	10
11	Interest Income on Corp										(96)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,455)	14
15	TOTALS (line 9+line14)						$ 14,668,300	$ 14,408,749			$ 1,027,906	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 72,284 Line # 36

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Alden Orland Park Rehab & HCC **#** 0042192 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	498,500	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	535,736	2
3. Under or (over) accrual (line 2 minus line 1).	$	37,236	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	551,800	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	589,036	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	355,797	8
	2001	474,443	9
	2002	438,258	10
	2003	414,031	11
	2004	535,736	12

Accrual is based on a 3% increase over prior year bill ($535,736)

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$		13
14	PLUS APPEAL COST FROM LINE 5	$		14
15	LESS REFUND FROM LINE 6	$		15
16	AMOUNT TO USE FOR RATE CALCULATION	$		16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alden Orland Park Rehab & HCC COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042192

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE (773) 286-3883 FAX #: (773) 286-3742

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	27-21-401-003-0000	Nursing Home Facility	$ 535,736.00	$ 535,736.00
2.	SEE	Related Party-AMS	$ 130,007.00	$ 6,206.00
3.	ATTACHED	Related Party-Forum	$ 15,792.00	$ 1,424.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 681,535.00	$ 543,366.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Alden Orland Park Rehab & HCC # 0042192 Report Period Beginning: 01/01/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 92,048 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	350,871	1997	$ 584,920	1
2					2
3	TOTALS	350,871		$ 584,920	3

Facility Name & ID Number Alden Orland Park Rehab & HCC # 0042192 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Related party-Forum			1978	$ 14,541	$	25	$	$	$ 14,541	4
5											5
6	200		1998	1997	12,679,210	314,835	40	316,980	2,145	2,534,359	6
7											7
8											8
	Improvement Type**										
9	RUN CABLE TO BUILDING/INSTALL 6 OUTLETS			1998	2,975	298	10	298		2,306	9
10	RELOCATION OF OUTLETS & POWER CIRCUIT			1998	1,648	165	10	165		1,305	10
11	INSTALL 6 WALL JACKS			1998	2,158		5			2,158	11
12	INSTALL CABLE			1998	4,446	445	10	445		3,557	12
13	REPLACE SPRINKLER HEADS			1998	6,236	624	10	624		4,729	13
14	INSTALL WALL PLATES			1998	4,608		5			4,608	14
15	Climate Service(boiler maintenance)			1999	14,529	726	20	726		5,085	15
16	Directional Boring(sprinkler system)			1999	5,400	360	15	360		2,460	16
17	Chicago Cooling(a/c unit repair)			1999	2,070	138	15	138		908	17
18	Church Landscape(floating swan island)			1999	3,400		5			3,400	18
19	Church Landscape(floating swan island)			1999	2,000		5			2,000	19
20	Watermangement(compressor)			1999	2,625	175	15	175		1,123	20
21	New Horizons Communications (light telephone sys)			2000	9,767	977	10	977		5,860	21
22	New Horizons Communications (light telephone sys)			2000	7,765	777	10	777		4,659	22
23	System Electric (wiring)			2000	1,384	69	20	69		415	23
24	Climate Services (pipe)			2000	1,674	84	20	84		502	24
25	Climate Services (pipe)			2000	1,689	84	20	84		507	25
26	Climate Services (pipe)			2000	1,684	84	20	84		505	26
27	Climate Services (pipe)			2000	2,376	119	20	119		713	27
28	GT Mechanical (heating/compressor repair)			2000	5,079	508	10	508	0	3,047	28
29	New Horizons Communications (light telephone sys)			2000	7,765	777	10	777		4,659	29
30	Alden Bennett Cons (time and billning material)			2000	2,073	207	10	207		1,105	30
31	Alden Bennett Cons (time and billning material)			2000	2,798	280	10	280		1,423	31
32	New Horizons Comm. (phone insall)			2000	4,437	444	10	444		2,662	32
33	Fox Valley Fire & Safety (sprinkler system)			2000	2,290	153	15	153		789	33
34	Alden Bennett Construction (time and material)			2000	2,915	292	10	292		1,482	34
35	Capps Plumbing (srvc/repair pump)			2001	1,977	132	15	132		626	35
36	Alden Bennett Construction (paving)			2001	9,328	622	15	622		2,539	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Alden Orland Park Rehab & HCC # 0042192 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Capps Plumbing (repair pump)	2002	$ 7,214	$ 481	15	$ 481	$	$ 2,805	37
38	Med-Con (alarm system)	2002	813	81	10	81		298	38
39	Alden Bennett Construction (time & material)	2002	4,008	267	15	267		980	39
40	Alden Bennett Construction (time & material)	2002	2,809	187	15	187		702	40
41	Alden Bennett Construction (time & material)	2002	2,365	158	15	158		604	41
42	Alden Bennett Cons.-2002 cost adjustment	2003	(4,558)	(304)	15	(304)		(1,089)	42
43	Alden Bennett Cons..auto. Door opener	2003	3,915	391	10	391		979	43
44	Alden Bennet Cons. laundry press/gas/ellec	2003	6,825	455	15	455		1,365	44
45	GT Mechanical-repair heat pump	2003	1,797	359	5	359		1,048	45
46	CSI Coker-rebuild dishwasher	2003	4,333	433	10	433		1,119	46
47	Real Green-sprinkler system repair	2003	3,600	720	5	720		1,860	47
48	Real Green-sprinkler system repair	2003	1,750	350	5	350		963	48
49	CSI Coker kitchen exhaust pipe repair	2003	1,728	346	5	346		835	49
50	CSI Coker-walk in freezer repair	2003	1,560	312	5	312		754	50
51	Alden Bennett Cons.-ejector pump repair	2003	1,182	236	5	236		571	51
52	Controlled Irrigation-sprinkler systen repair	2003	2,552	510	5	510		1,191	52
53	Alden Bennett Cons-ejector pump repairs	2003	2,991	598	5	598		1,446	53
54	B&K Lawnscaping-crushed stone walkway base	2003	1,400	140	10	140		292	54
55									55
56	Alden Bennett - Repairs	2004	1,700	113	15	113		123	56
57	Top Notch - Repairs	2004	2,189	146	15	146		158	57
58	Alden Bennett Construction - laundry press/gas/electric/pipe	2004	4,062	203	20	203		355	58
59	GT Mechanical-repair heat pump	2004	1,083	54	20	54		95	59
60	GT Mechanical-replace A/C compressor unit	2004	8,600	573	15	573		860	60
61	Insurance refund on above asset	2004	(3,600)	(240)	15	(240)		(360)	61
62	GT Mechanical-repair heater leak	2004	583	117	5	117		155	62
63	GT Mechanical-repair valve leak	2004	718	144	5	144		168	63
64	GT Mechanical-heater repair	2004	753	151	5	151		176	64
65	New Horizons - Phone line repair	2004	2,793	279	10	279		326	65
66	B & K Lawnscaping- crushedstone walkway base	2004	2,420	161	15	161		269	66
67	Alden Bennett - Plumbing Repair	2004	866	173	5	173		231	67
68	GT Mechanical - Repair compressor leak	2004	700	140	5	140		198	68
69									69
70	TOTAL (lines 4 thru 69)		$ 12,879,996	$ 331,107		$ 333,252	$ 2,145	$ 2,633,508	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Orland Park Rehab & HCC # 0042192 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 12,879,996	$ 331,107		$ 333,252	$ 2,145	$ 2,633,508	1
2									2
3	GT Mechanical - Repair cooling fan	2004	1,256	251	5	251		335	3
4	GT Mechanical - Repairs	2004	679	136	5	136		204	4
5	Top Notch - Repairs	2004	839	168	5	168		266	5
6	GT Mechanical - AC maintenance/repair	2004	1,108	222	5	222		388	6
7	GT Mechanical - Replace CFM & contactor	2004	1,126	113	10	113		188	7
8	Replace condenser fan motor	2004	1,204	120	10	120		211	8
9	Building Repairs	2004	5,871	391	15	391		522	9
10	A&B Custom Cable TV Service, Inc. - Inst cable jacks	2004	8,120	812	10	812		1,624	10
11	GTMECH-Replace Gas Valve in the RTU	2005	2,165	144	15	144		144	11
12	TOPNOT Commercial Kitchen	2005	1,735	116	15	116		116	12
13	New Horizons Phone Repair	2005	2,461	185	10	185		185	13
14	Dryer and Condensing Unit	2005	1,309	98	10	98		98	14
15									15
16	ABC Installed Cabinets and Drawers	2005	5,332	178	15	178		178	16
17	New Horizons CRD 6 Circuit	2005	2,285	57	10	57		57	17
18	New Furnance	2005	2,299	77	5	77		77	18
19	12 New Phones	2005	3,559	30	10	30		30	19
20	ABC repair work on entry ramp and ramp walls	2005	5,211		15				20
21	Millcar Milliken Carpets	2005	18,160	757	10	757		757	21
22	Asphalt the Parking Lot	2005	1,806	45	10	45		45	22
23	Asphalt the Parking Lot	2005	1,787	45	10	45		45	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,948,308	$ 335,051		$ 337,196	$ 2,145	$ 2,638,976	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Orland Park Rehab & HCC # 0042192 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 12,948,308	$ 335,051		$ 337,196	$ 2,145	$ 2,638,976	1
2									2
3	Related Party-Forum Prof Center Building:								3
4	Leasehold Improvement-Remodeling	1980	11,034		15			11,034	4
5	Leasehold Improvement-Remodeling	1980	17,284		20			17,284	5
6	Leasehold Improvement-Tenant Improvement	1987	893		13			893	6
7	Leasehold Improvement-AMS Remodel	1988	14,339		10			14,339	7
8	Leasehold Improvement-Roof	1994	3,203	200	16	200		2,204	8
9	Leasehold Improvement-Build.Improv.	1996	1,129	71	16	71		702	9
10	Leasehold Improvement-Asphalting	2000	88		3			88	10
11	Leasehold Improvement-DAI	2001	154	15	10	15		64	11
12	Leasehold Improvement-Bathrooms	2002	667	76	7	76		242	12
13	Leasehold Improvement-Suite Renovation	2003	1,638	164	10	164		491	13
14	Leasehold Improvement-Plumbing, Construct, Concrete, Doors, etc	2004	1,801	329	7	329		465	14
15	Leasehold Improvement-Add-on Improvement, fixture base	1980	71		23			71	15
16	Leasehold Improvement-Add-on Improvement, lighting base	2001	123	25	5	25		117	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26	Related Party-AMS:								26
27	Leasehold Improvement-Remodeling	1993	5,938		7			5,938	27
28	Leasehold Improvement-Remodeling	2002	4,861	694	7	694		1,997	28
29	Leasehold Improvement-Remodeling	2003	5,085	726	7	726		2,072	29
30									30
31									31
32									32
33	Forum Extended Care, LLC-building/building improv	1999	12,928	306	30	306		2,139	33
34	TOTAL (lines 1 thru 33)		$ 13,029,545	$ 337,657		$ 339,803	$ 2,145	$ 2,699,115	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Orland Park Rehab & HCC # 0042192 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,291,449	$ 99,742	$ 99,742	$	Various	$ 639,849	71
72	Current Year Purchases	23,600	1,232	1,232		Various	20,029	72
73	Fully Depreciated Assets	107,271	1,319	1,319		Various	107,271	73
74								74
75	TOTALS	$ 1,422,321	$ 102,292	$ 102,292	$		$ 767,150	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Car Engine/Bus/Van	Various/Dodge	98-04	$ 8,164	$	$	$	3	$ 8,164	76
77	Midwest Transit	Ford Eldorado	2000	49,826	6,643	6,643		5	49,826	77
78	Related Party-AMS	Various/Bus/Autos	1998-2004	4,706	111	111		3	4,638	78
79	Water hoses relace on Auto	Various	2005	1,537	231	231		5	231	79
80	TOTALS			$ 64,233	$ 6,985	$ 6,985	$		$ 62,859	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 15,101,019	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 446,935	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 449,080	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,145	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,529,124	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Alden Orland Park Rehab & HCC # 0042192 Report Period Beginning: 01/01/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Related Party cost is backed out.
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 4/1/96
Ending 12/31/05

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$ 1,200,576
13.	/2007	$ 1,200,576
14.	/2008	$ 1,200,576

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ 15,779 Description: Copy Machine, 13,079.20 & Postage Meter, 2,700
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Related Party - AMS	Various	$ #######	$ 26,936	17
18					18
19					19
20					20
21	TOTAL		$ #######	$ 26,936	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Alden Orland Park Rehab & HCC # 0042192 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   Skilled Nurses on-site

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Alden Orland Park Rehab & HCC # 0042192 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 617,189	$		$ 617,189	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			90,545			90,545	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			558,660			558,660	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	See Page 16A	# of prescrpts				524,973		524,973	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	See Page 16A				(31,025)	155,906		124,881	13
14	TOTAL			$		$ 1,235,369	$ 680,879		$ 1,916,248	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

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XIV. Special Services (Direct Cost)

Col 5: PT,OT, & ST
Col 6: Supplies

Service Description	Col. 1: Ref. No.	To Pg 16: Col. No.		
1. OT	39-3	T	617,189	
2. ST	39-3	T	90,545	
3.				
4. PT	39-3	T	558,660	
5.				
6.				
7.				
8.				
Phamacy Supplies per GL			368,860	
Manual Input from Related Party- Forum Drugs			156,113	From Pg 6C
9. Total to line 9 Pharmacy	See Pg 16A	T	524,973	
10.				
11.				
12. Exceptional Care-Salaries:	See pg 16A	T	-	
12. Exceptional Care-Supplies:	See pg 16A	T	-	
Total Exceptional Care (Line 12, Col 8)			-	
13. Other:	See Pg 16A			
13. Col 5: Manual Input: Related Party - CPT			(31,025)	From Pg 6D
Other			601,109	
Manual Input: Related Party - Prism			(170,765)	From Pg 6B
Manual Input: Related Party FECII - I.V.			(279,935)	From Pg 6C
Manual Input: Related Party FECII- Wound Vac			(235)	From Pg 6C
Oxygen, from reclass worksheet			5,732	From Pg 24
13. Col 6: Supplies Total		T	155,906	
13. Total Line 13, Column 8			124,881	
14. Total			1,916,248	

Facility Name & ID Number Alden Orland Park Rehab & HCC **#** 0042192 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (105,571)	$ (105,571)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 142,306)	1,925,302	1,925,302	3
4	Supply Inventory (priced at)	51,637	51,637	4
5	Short-Term Investments		2,517,943	5
6	Prepaid Insurance		34,798	6
7	Other Prepaid Expenses	3,950	3,950	7
8	Accounts Receivable (owners or related parties)	3,445,896	4,134,419	8
9	Other(specify):	49,687	49,687	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,370,901	$ 8,612,165	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,553	7,553	12
13	Land		584,920	13
14	Buildings, at Historical Cost		12,593,418	14
15	Leasehold Improvements, at Historical Cost	275,258	275,258	15
16	Equipment, at Historical Cost	322,129	1,389,259	16
17	Accumulated Depreciation (book methods)	(295,402)	(3,384,252)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	44,004	79,854	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(3,483)	(6,022)	20
21	Restricted Funds		850,814	21
22	Other Long-Term Assets (specify):	58,937	58,937	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 408,996	$ 12,449,739	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,779,897	$ 21,061,904	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,660,163	$ 1,660,163	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	306,180	306,180	28
29	Short-Term Notes Payable	1,589,090	1,697,474	29
30	Accrued Salaries Payable	469,518	469,518	30
31	Accrued Taxes Payable (excluding real estate taxes)	77,518	77,518	31
32	Accrued Real Estate Taxes(Sch.IX-B)		551,800	32
33	Accrued Interest Payable	37,100	108,303	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		270,932	270,932	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,410,501	$ 5,141,888	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,573,203	2,573,203	39
40	Mortgage Payable		14,300,366	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,573,203	$ 16,873,569	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,983,704	$ 22,015,457	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,203,807)	$ (953,553)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,779,897	$ 21,061,904	48

***(See instructions.)**

Facility Name & ID Number Alden Orland Park Rehab & HCC **#** 0042192 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,965,363)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,965,363)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	761,556	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 761,556	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,203,807)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Alden Orland Park Rehab & HCC # 0042192 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 13,107,152	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 13,107,152	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	26,844	6
7	Oxygen	8,546	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 35,390	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	43,010	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,893	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	(6,600)	19
20	Radiology and X-Ray		20
21	Other Medical Services	19,537	21
22	Laundry	1,375	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 59,215	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	97	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 97	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Page 19A	15,951	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 15,951	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 13,217,805	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,824,787	31
32	Health Care	3,684,278	32
33	General Administration	2,618,622	33
	B. Capital Expense		
34	Ownership	1,935,056	34
	C. Ancillary Expense		
35	Special Cost Centers	2,284,006	35
36	Provider Participation Fee	109,500	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,456,249	40
41	**Income before Income Taxes (line 30 minus line 40)****	761,556	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 761,556	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Yet Done If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Orland Park
2005

	Column 1 Amount

	Column 1 Amount

Page 19A

Must be submitted if there is a balance on Line 28. You need only report the info that has a balance.

Miscellaneous Income gl 4977	**487.35**		
Recovery of Bad Debts (private only, is not offset on Schld V)	2,774.61	487.35	Utility Refunds
Prior year AP Adjustment	12,688.62		
Total of line 28	15,950.58		
		487.35	

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Facility Name & ID Number Alden Orland Park Rehab & HCC # 0042192 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,262	2,262	$ 82,032	$ 36.27	1
2	Assistant Director of Nursing	792	792	26,100	32.95	2
3	Registered Nurses	32,665	34,520	1,007,574	29.19	3
4	Licensed Practical Nurses	23,560	24,837	557,627	22.45	4
5	CNAs & Orderlies	87,870	94,326	1,128,972	11.97	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,843	2,031	28,069	13.82	8
9	Activity Director	2,080	2,080	55,977	26.91	9
10	Activity Assistants	10,706	11,182	150,204	13.43	10
11	Social Service Workers	2,720	2,720	53,577	19.70	11
12	Dietician					12
13	Food Service Supervisor	4,160	4,160	62,368	14.99	13
14	Head Cook	5,916	5,916	77,632	13.12	14
15	Cook Helpers/Assistants	45,529	47,186	422,288	8.95	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	52,717	25.34	17
18	Housekeepers	21,405	22,997	242,626	10.55	18
19	Laundry	7,428	8,410	84,319	10.03	19
20	Administrator	2,200	2,200	92,201	41.91	20
21	Assistant Administrator	2,080	2,080	68,532	32.95	21
22	Other Administrative	8,392	8,392	215,736	25.71	22
23	Office Manager					23
24	Clerical	4,864	4,864	50,190	10.32	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,960	1,985	45,719	23.03	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,080	2,080	34,073	16.38	31
32	Other Health Ca Alz Sup,Aid-Clinic	9,579	9,810	147,414	15.03	32
33	Other(specify) Beautician	2,064	2,064	47,643	23.08	33
34	TOTAL (lines 1 - 33)	284,235	298,974	$ 4,733,590 *	$ 15.83	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	800/Mo	$ 9,600	1-3	35
36	Medical Director	1900-5mo,3000-7	30,500	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	400/mo	4,800	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	77/mo	922	11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 45,822		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Alden Orland Park Rehab & HCC # 0042192 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Carole Considine	Administrator	0	$ 89,107
Gerald Mertes III	Assistant Admin	0	71,626
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 160,733

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Alden Management	Management Fees	$ 983,769
BDO Seidman	Accounting Fees	7,847
Ken Fisch	Legal Fees	40,531
Greenburg & Hermann	Legal Fees	8,534
Medi.com	Billing Consultants	390
SMS	Billing Consultants	1,493
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 1,042,564

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 111,091
Unemployment Compensation Insurance	14,262
FICA Taxes	461,129
Employee Health Insurance	62,856
Employee Meals	21,469
Illinois Municipal Retirement Fund (IMRF)*	
Union, Health, & Welfare	42,158
Pension	31,499
Drug tests, 401K Match, & Vaccinations	5,909
Dental & Life insur, relations, tuition, misc	5,517
TOTAL (agree to Schedule V, line 22, col.8)	$ 755,890

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,313
Health Care Worker Background Check	669
(Indicate # of checks performed 96)	
IL Health Care Assoc	7,400
Dues & Subscriptions	5,309
Surety Bond Fees	655
Related Party - AMS	569
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,915

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Various auto & travel	1,910
Gas	982
Related Paty - AMS	15,782
Seminar Expense	
Alzheimers Assoc	524
Deming Training	1,250
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 20,448

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Alden Orland Park Rehab & HCC # 0042192 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	Boiler repair	11/98	$ 1,672	3	$ 0	$	$	$	$	$	$	$	$
2	Boiler maintenance/aj	2/99	2,073	3	58	0	0	0					
3	Heating repairs	12/99	1,797	3	549	0	0	0					
4	A W S DUSTRUBUTING	2/00	3,093	3	1,031	0	0	0					
5	CLIMATE SERVICES (I	2/00	1,636	3	546	0	0	0					
6	GT MECHANICAL (sum	6/00	1,863	3	621	0	0	0					
7	CAPPS PLUMBING (fou	3/00	2,781	3	927	154	0	0					
8	CAPPS PLUMBING (clea	3/00	1,460	3	487	80	0	0					
9	D.B.S CONTRACTING (r	7/00	2,790	3	930	0	0	0					
10	Painting > $1,500 -1999	7/99	8,058	3	1,343		0	0					
11	Painting > $1,500 -2000	7/00	4,336	3	1,445	723	0	0					
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 31,559		$ 7,937	$ 957	$	$	$	$	$	$	$

Facility Name & ID Number Alden Orland Park Rehab & HCC # 0042192 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? _____
If YES, give association name and amount. **Il Health Care Assoc. $7,400**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **11 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **27,848** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **109,500**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **21,469** Has any meal income been offset against related costs? **No** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **N/A** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **0**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Not Required**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.